THE INSANE CRIMINAL AS THERAPIST

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This paper will describe briefly the development of a sequence of complementary milieu therapy programs for mentally ill offenders in Oak Ridge, the Maximum Security Division of the Penetang Psychiatric Hospital, Penetanguishene. It up-dates an earlier account of a pilot project (Barker and Mason, 1968).

Comprising eight 38-bed wards, each lined with barred individual rooms and served by a complex of storage rooms and meeting space, this structurally-designed prison functions as a mental hospital, and admits patients in four main streams, serving in its various capacities the entire Province. The courts send male persons found unfit to stand trial or not guilty by reason of insanity, and others for thirty and sixty-day periods of assessment and observation, where their charges or instability are serious enough to rule out the use of a local psychiatric unit. From the federal Penitentiaries at Kingston and Stony Mountain, and the Ontario Department of Reform Institutions and jails, come those mentally ill inmates whom treatment facilities there are not equipped to help. From the other twenty-two mental hospitals serving the Province arrive elopers and persons too assaultive or destructive to be treated there.

Since the institution opened in 1933, the population has been composed of a fast-moving stream of patients who return to court, a slower-moving group who stay from a year to five years before a release is possible, and the balance who, because of the seriousness of their legal and psychiatric situations, do not expect to be released for ten, twenty, or thirty years. Most members of these last two groups are severely mentally ill, many not obviously so to the short-term observer, and few of them either recognize or agree to the fact of their illness.

It is tempting to view the superficially sane patient as more bad than mad, and much confusion may exist about the best way of viewing mental illness, even when it is agreed to be present (Siegler and Osmond, 1966). The approach adopted towards such patients in Oak Ridge's recent past has been to provide tranquillizers for many, E.C.T. for a few, and for all

a comfortable, but custodial, environment where progress is measured in amenities.

Our present point of view is that most people *can* benefit from more active types of treatment than tranquillizers, that the insane and dangerous criminal *must* if he is to be released, and the ordinary thug *ought to*, if it will decrease the crime rate.

Since, for the insane criminal, the alternative to successful treatment is lengthy incarceration, we have since 1965 been developing intensive social therapy programs aimed at compressing into a few intensive treatment years the presumed benefit of custodial decades. We have been doing this in the relative absence of professionally trained staff, and with an attendant staff which, by nature and nurture, is custodially-oriented. Since we are keenly aware that for many of our patients the first symptoms of a relapse may again be murder, rape or arson, our objective is a major reconstruction of the personality, as opposed to supportive or repressive measures. If we were not naively idealistic, we would not have begun the process at all, but now with it under way, the undertaking seems preferable to the defeatist inertia of comfortable custody in terms of the heightened morale of both staff and patients, and the increased safety of more informed assessments of the patients' readiness for release, to say nothing of the possibility of the freeing of healthy human potential.

It is thought that about half of the patients in Oak Ridge might benefit from this form of therapy, and in a two-year period, a five-unit treatment program has been developed which constitutes our Social Therapy Unit. Three 38-bed Encounter Therapy Units, one 22-bed Training Unit and one 16-bed Compressed Encounter Therapy Unit, are staffed by three Social Work Assistants with B.A.'s, one M.S.W. Social Worker, and a full complement of Attendants — three for morning and afternoon shifts, and one at night. In the first year, a psychiatrist worked full time, in the second year half-time, in the development of these programs.

A number of fundamental assumptions (discussed in detail elsewhere) guided their evolution (Barker and Mason, 1968).

The Major Assumptions

1. *Illness as the failure of communication*
   Whatever the causes of it, mental illness is felt to be the sum of the ways in which the patient is unable to relate satisfactorily either with himself or others.

2. *Dialogue as therapy*
   Genuine and spontaneous dialogue with others, as Buber defines it (Buber, 1961), is thought to be the substance and achievement of therapy. Once it is achieved, it seems to us

that the symptoms of illness will wither away, starved of the falsity that maintains them.

3. *The patient as agent of therapy*
The shortage of professional staff, their shortcomings as therapists, and the existential equipment of patients to help one another, suggest that perhaps they should be the principal agents in their own treatment. Their shortcomings as therapists seem to be minimized by the reciprocal checks and balances that they can exert on one another in appropriate group settings.

4. *Total experience*
It is a major assumption that as many hours of the day as possible should be used to help the patient change in a way that will end his confinement.

5. *The legitimacy of coercion*
Where a patient is confined against his will until he changes his behaviour, it seems humane to use force at least to the point of increasing his awareness of himself and others so that, as far as can be determined, what he does, he consciously chooses to do.

Development I: The Pilot Project

Over a twelve-month period from September 1965 to September 1966 what later came to be called an Encounter Therapy Unit was developed on one of the wards in Oak Ridge (G Ward), starting from a foundation of a single Ward Council meeting every two weeks, and reaching peaks of ninety-hour a week programmed group activity. Patients were initially selected for the ward on the basis of verbal ability, and most were relatively young and intelligent psychopathic or schizophrenic offenders between 17 and 25. The program, described in detail elsewhere (Barker and Mason, 1968; Mason, 1967; Hollobon, 1967) was in a continuous state of change according to the perceived needs of the unit, but a formal social structure eventually emerged which is now common to all our structured milieu therapy programs.

Roles in work settings occupy about a third of the patient's day. For the remainder, he moves through an intensive series of committees and groups which place him in different settings with different role expectations. The units operate on an almost staffless basis that frees them from dependence on professional staff resources except for the use of medication. Confrontation and communication take place between patients at a relatively intense level. Patient committees generate, maintain and enforce participation in intensive and complex time-tables of ward

meetings, Small Groups*, and drug treatments, which have employed amytal-methedrine, tofranil-dexamyl, L.S.D.-25, and scopolamine-methedrine as forms of defence-disrupting therapy (Barker, Mason and Wilson, 1968). For two or three hours every day, meetings with all thirty-eight patients present discuss feedback from the five committees and five Small Groups that meet daily. Consistently, a mirroring and confronting approach is maintained which emphasizes individual illnesses as they appear in here-and-now situations. Repetition and sanction are employed to drive home to the patient the fact of his illness, and the means of overcoming it — the free and open expression of thoughts and feelings.

Because of the planned anxiety-arousal measures, some patients become homicidal or suicidal risks, and they are cared for by an elaborately organized security system (Barker, Mason and Walls, 1968), which keeps them in total participation under conditions of safety.

Formal contact is maintained with the staff by a Liaison Committee comprising four patients and the Ward Supervisor. Perhaps the most important structural characteristic of the patient committee system is the way it operates with little dependence on staff to initiate and sustain proceedings. Recommendations are made to them directly, and the Ward Supervisor maintains close contact with all developments, but in practice seldom has to exercise his unquestioned power to veto any committee decision. Staff are by decree not expected to become involved with patients in discussion or explanation of their own feelings or thoughts. Therapy is equated to open and honest dialogue, and is the business of the patients, not the staff — a distinction which has been found both necessary and advantageous in our setting.

After a twelve-month period, during which the remainder of the patient body in Oak Ridge became accustomed to the new concepts that were filtering out of the pilot Encounter Therapy Unit, and attendant staff no longer expected the daily collapse of the community into an Armageddon of violence and madness, growing enthusiasm on other wards seemed to signal their readiness for milieu therapy programs.

Development II: Expanding Operations

In an eight-month period, a Social Therapy Unit crystallized, with four units operating at various levels of intensity. These developed at different rates, reflecting the various populations of the wards, but the pattern of committees, "Small Groups" and ward meetings repeated itself in a way that supports a notion of its general applicability. With minor variations, programs have developed on three Encounter Therapy Units into a daily pattern of three hours' paid work in Industrial Therapy or

* A colloquial term for ad hoc staffless therapy groups for upset patients, thought to be the core of the programs.

school, four hours in intensive group inter-action, and four hours' evening recreation, which includes physical training, dances, sing-songs, and volunteer activities.

Development III: The Training Unit

At the beginning of treatment we find it helpful to attempt some modification of the rigid framework of subcultural paranoia that many patients bring to us from reformatory or penitentiary. Bright, tough and manipulative, these persons present a formidable threat to the principles of openness and communication on which our programs are based. Encounter Therapy Units do not seem well-adapted to receive such patients initially. It is difficult and time-consuming to convince the newly-admitted and well-defended psychopath, for example, of his sickness and need for treatment. With the aim of facilitating the process, a 22-bed Training Unit was established where new admissions to the Social Therapy Unit pass through a program of ward meetings, group discussions and lectures. Patient-prepared papers on communication, disruption, manipulation, defence mechanisms, logical fallacies and interpersonal behaviour, are discussed intensively; simple multiple-choice examinations are administered until it is clear that the individual has at least memorized the basic principles and assumptions of milieu therapy. Committees from other Encounter Therapy Units visit the Unit regularly to give first-hand accounts of their roles in their Units, and to look for patients who might be suitable for transfer to their particular wards.

The Unit is effectively directed by four patient "Trainers" who have experienced one or two years' intensive milieu therapy. Some of them have been in Department of Reform Institutions, talk the language and practice the skills, which they now use in support of the institution's goals. They are paid an hourly rate for their work, just as they would for any other Industrial Therapy assignment in the hospital.

The program has the dual objective of familiarizing new patients with milieu therapy, and socializing them to a point where they will be less of a problem to an Encounter Therapy Unit. Hopefully, also, they will grasp the eagerness of the administration to involve them in a mode of interaction which appears more valuable than swapping lies about past, or planned, anti-social acts.

The Limitations of Encounter Therapy Units

Three major trends seem to limit the value of Encounter Therapy Units. With disturbing persistence, some patients make "public" statements supporting whatever is currently believed to be approved by authority, and private statements of quite different content. The individual finds himself on occasion unable to express his true feelings either in public or

in private settings, and a triple division into public, friendship group, and intra-personal beliefs can occur.

Secondly, a trend towards excessive organization limits the capacity of the program to help slick and intelligent patients who can manipulate their way through the loopholes in an organized structure. In addition, those who can organize and direct the treatment methods of others are often *ipso facto* in a position where such efforts cannot reach them. Their already elusive pathologies are further obscured by a galaxy of bureaucratic duties, which they have no trouble in fulfilling. Their immaculate performance in the organization seems to make other patients unwilling and sometimes unable to identify their illnesses and treat them. In brief, some patients can play the therapy game and remain untouched by it.

Finally, although the observer system operates to reduce considerably the chances of suicide or homicide, it is only as effective as the insight of the patients and staff who attempt to spot the risks. When a certain level of group anxiety is reached in a setting where patients live in rooms with potential weapons like coffee jars (knives), sheets (ropes), and bedsteads (clubs), it becomes prudent to doubt the ability of even the best committee and staff to identify acting-out risks. Perhaps by acting on the assumption that it is best to be too careful, we have so far experienced no serious trouble in this area, but the possibility remains a constant concern.

Development IV: Questioning Assumptions and Eliminating Risks

To overcome these limitations on patients who realize that the safe intensity level on Encounter Therapy Units is not significantly affecting them, a Compressed Encounter Therapy Unit was established. After two months of exhaustive patient discussion, a program was conceived that seemed to meet the two most basic conditions: total safety from homicide and suicide, and total personal confrontation. It is rewardingly convenient that measures serving one of these goals almost without exception serve both.

The Compressed Encounter Therapy Unit housing this program is entered by a grill gate, and comprises one large room about four yards by twenty, a smaller room with open toilets and washbasins, and a shower room without partitions. Except for such things as dental or X-ray work, no patient leaves this area, and when he does he is very closely observed. All windows are screened, all electric outlets and lights protected. Meals are served on paper plates and cups, and eaten in the unit. Except for their cushions, mattresses, uniform khaki clothes, toothbrushes, towels and soap, there are no other objects in the unit. No chairs, shoes, books, television, radio — nothing. Every patient is always in the presence of at least three others, and for the overwhelming majority of the time, the entire group. No room used by the patients has a door on it. All sleep

together in a large, brightly-lit room at night, where close observation is kept by an attendant, two patient observers who stay alert on dexedrine, and a closed-circuit television camera. There is nothing to do except to talk to one's peers, or keep silent and think, withdrawal being reduced to psychological privacy. Mail and visits are discouraged as outlets into fantasy, away from the here-and-now.

While a list of these measures reads like unabashed barbarism or perverted economy, they guarantee as far as possible the safety of patients to confront the genuine emotions in one another without undue concern for homicide or suicide. In some ways, this program resembles Marathon T-Group sessions which have been developed for relatively "normal" persons to run continuously for several days (Bach, 1964). Until the value of this program (which began in October 1967) is better established, it is felt desirable to include only volunteer patients. Since many who are convinced of the gravity of their legal and psychiatric situations are keen to participate in any program that might free them from their illness and hence from the hospital, this presents no problems. Of the first group of sixteen patients, which remained in the unit for four months, eleven had experienced at least a year of highly organized milieu therapy prior to their Compressed Encounter Therapy. Fourteen of them fell into the 18-30 age group, and all were of average or bright intelligence, with a range of education from Grade 7 to some university. Eight were diagnosed Personality and Character Disorders on admission, eight suffered from schizophrenic types of disorder. Fourteen were charged with criminal offences, seven with capital murder, one with rape, one with attempted murder, and the remainder with less startling offences, like possession of a deadly weapon, assault, armed robbery, and theft.

Human Relations Training literature and other papers thought likely to stimulate non-dogmatic exchanges are introduced and exhaustively discussed as a step towards undermining the systems of beliefs about health and illness that are felt likely to block treatment in this special setting. The sole administrative instrument of patient action is the total community meeting, which makes all recommendations for defence-disrupting medication, and performs all the functions that on other units are delegated to a complex bureaucracy of committees. Scopolamine and methedrine are administered to at least four patients each week, as measures to focus group activity, reduce individual defences, and hasten confrontation. Since all members of the community now live in one anothers' presence, it is no longer necessary to employ elaborate observation procedures, and patients who are medicated wander quite freely. Tranquillizers are never used, even in cases where patients become "psychotic". We conclude with Laing (1967) that intervention in the process of a phychosis may often frustrate or interrupt an innately helpful series of events. Sustained and genuine concern, plus the elimination of physical danger, seem preferable to chemicals or electricity, when such a milieu can be established.

Attendant Staff

Each ward is staffed by a permanent supervisor and two other attendants, who frequently change from ward to ward. The attendants' norms of strict adherence to working hours, the job specifications requiring two staff members "observing" on the ward and one at the front, and the high cost of overtime pay, all combined to create a situation where the changes described in this paper have taken place without having formal meetings or discussion groups with attendant staff, although informal communications between a few key attendants and professional staff occur frequently on a one-to-one basis.

Early in the process of change, attendants developed anxieties about the disorder and madness that might be unleashed in a move towards more active treatment. A tactical device of great value in smoothing the passage of innovations was the practice of making no move that diminished security. Perhaps surprisingly, this did not interfere with the intensity of interaction in the hospital and, reassuring the staff that their primary role function as they saw it was not being weakened, helped gain their support. Consistently backing all changes was the innovators' total control of line authority, which was recognized universally, but only tactfully and rarely exercised.

Senior attendant staff play a key role in the operation of all units, legitimizing and monitoring all patient action. Their support of, and belief in, actual treatment goals is less important than their support of the mechanisms used to achieve them. Overt opposition may be taken account of and allowed for administratively. Supervisors whose attitudes are basically custodial, but tolerant of patient committees, can and do make positive contributions. Supervisors who choose to *covertly* undermine changes can act as a formidable brake on development.

Relevance of the Program

On a foundation of no special staff training or hiring, active programs involving 150 patients have been established. On the surface, it seems obvious to us that our patients are at least more usefully occupied and happier now than when they lounged through a perpetual coffee break, colluding in one anothers' fantasies, or busied themselves with statistically impressive Industrial Therapy programs, which lighten confinement and appease the public, but leave pathology intact. An objective comparison study with follow-up has been initiated to assess the effects of this type of program on recidivism rates.

We see ourselves offering little of value either to the first offender, who is very often unlikely to repeat after a stay in the existing Department of Reforms Institutions facilities, or to the offender who, after a long series of incarcerations, is probably beyond the help of any treatment. Our

efforts may be relevant to the persons falling between these two categories too ill for supportive or repressive measures, but still amenable to therapeutically-organized programs using one another as therapists.

Summary

The Social Therapy Unit of the Penetang Psychiatric Hospital offers three types of milieu therapy programs to 150 patients, most of whom have been charged with criminal offences. After a sketch of the development of these programs in this previously custodially-oriented institution, which operates with a minimum of professional staff, the structure and operation of each type is described. The 22-bed Training Unit familiarizes patients with milieu therapy concepts, using a didactic approach. This is a prelude to the patient's entry into one of the three, 38-bed Encounter Therapy Units, where almost autonomous patient committees organize group-oriented treatment programs. A Compressed Encounter Therapy Unit of sixteen beds offers unique conditions of maximum confrontation and maximum protection from the risks of homicide and suicide that accompany high intensity treatment in this institution.

Evaluative research is being initiated in conjunction with the Ontario Department of Reform Institutions to compare the effects of this hospital milieu with that of a reformatory on young offenders who are likely to repeat.

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